

PATIENT REGISTRATION

PERSONAL INFORMATION

Patient's Name _____ Home Phone _____

Parent's Name (minors only) _____ Cell Phone _____

Street Address _____ Email Address _____

City, State, Zip _____ Social Security # _____

Birth Date _____ Marital Status S M D W Sex M F

Family Doctor & Phone # _____ Emergency Contact _____

Emergency Contact Phone _____

Reason for visit _____

May we leave voice mails at the above telephone numbers? YES / NO If so, which? Home / Cell

May we send you emails (i.e. appointment reminders, product and services offerings?) YES / NO

WHERE DID YOU HEAR ABOUT US (Circle one or more):

YELLOW PAGES ER PHYSICIAN FRIEND PATIENT SEMINAR WEBSITE OTHER _____

EMPLOYMENT INFORMATION

Employer _____ Phone _____

Street Address _____ City, State, Zip _____

HEALTH INSURANCE INFORMATION(If Applicable)

Insurance Company _____ Identification & S.S. _____

Subscriber's Name _____ Subscriber Date of Birth _____

Would you be interested in receiving a complimentary consultation or information regarding any of the following Spa services? (Please circle all that apply)

Skin Care Analysis Laser hair Removal Botox Restylane Perlane Radiesse

Facial Treatments/Peels Photofacial Treatments Rytec Portrait Skin Resurfacing Permanent Make-up/ Skin Needling

Skin Care Products Vein Treatments Waxing/ Eyebrow Shaping Gift Certificates

I confirm that the information provided above is correct and I have not withheld any information that may be relevant to my procedure or treatment.

Signature _____ Date _____
